

FILED SEP 28 1943 49

Primary Registration District No. 1002

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: R.C. TB Hosp. I  
(If not in hospital or institution, write street number and location)  
(d) Length of stay: in hospital or institution 29 6m 18d.  
(Specify whether years, months or days) 27 yr.

3. (a) PRINT FULL NAME

Mary Pospeschil

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. none

4. Sex F 5. Color of face White 6. (a) Single, widowed, married, divorced, Separated

6. (b) Name of husband or wife Frank 6. (c) Age of husband or wife if alive 40 years

7. Birth date of deceased. 2 23 1904  
(Month) (Day) (Year)

8. AGE: Years 39 Months 6 Days 22 If less than one day \_\_\_\_\_ min. 36

9. Birthplace Warendsburg Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife at home

11. Industry or business \_\_\_\_\_

12. Name Robert M. Powell

13. Birthplace Warendsburg Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Mary Bell Hull

15. Birthplace Warendsburg Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Records R.C. TB Hosp  
(b) Address Leads Mo.

17. (a) Burial (b) Date thereof 9-18-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Floral Hills, Mollody McElroy  
18. (a) Signature of funeral director Kansas City Mo.  
(b) Address \_\_\_\_\_  
19. (a) 9-16-43 (b) J.E. Brown, Sep.  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4320 Spruce  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 15  
year 1943 hour 7.50 minute P. M.

21. I hereby certify that I attended the deceased from 2-27-41  
\_\_\_\_\_, 19\_\_\_\_, to 9-15 \_\_\_\_\_, 1943  
that I last saw her alive on 9-15 \_\_\_\_\_, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis 3 1/2 yrs.  
Duration

Due to \_\_\_\_\_  
Due to 1381

Other conditions Epilepsy 4 yrs.  
(Include pregnancy within 6 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
\_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(b) Means of injury \_\_\_\_\_

23. Signature Matthew J. Noon (M. D. or other) \_\_\_\_\_  
Address Leads Mo. Date signed 9/18/43

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
.....  
working under my personal supervision.

Registered Apprentice No.....  
Signed *Russell W. France*  
Licensed Embalmer No. *4255*  
P. O. Address *K.C. MO*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**